Public Employees Benefits Board (PEBB)

Request for Certification of Disabled Dependent

■ Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.

According to state law, a disabled dependent must meet the following qualifications:

1. Must have had his/her disability occur prior to age 20 or while a full-time student (through age 23); and
2. Must be incapable of self-support due to his/her disability.

Subscriber: Complete subscriber and dependent sections; you must have your doctor complete the physician section on the back of this form.

Subscriber Information

Last name	First name	Middle initial	Social security number		
Address			City	State	ZIP Code
Work phone number			Home phone number		

Dependent Information

Last name	First name	Middle initial	Social security number

Date of birth (mm/dd/yyyy)	Age when disability occurred	Relationship to subscriber	Was this dependent a full-time student at the time of disability?
		❑ Son ❑ Daughter ❑ Other:	❑ Yes ❑ No

❑ Yes ❑ No Has this dependent ever been employed?

❑ Yes ❑ No Is this dependent currently employed?

List names and addresses of employers and dates employed (use back of form if necessary):

_____

_____

_____

_____

Insurance coverage is determined through verification of eligibility by the Washington State Health Care Authority. I certify that, to the best of my knowledge and belief, my family members and I are eligible for the coverage requested. This form supersedes all previous forms I have submitted for Public Employees Benefits Board medical/dental coverage. A premium deposit does not guarantee coverage and will be refunded if I am determined to be ineligible for coverage.

Washington State law may require disclosure of any information I submit as public record. The Health Care Authority's Privacy Notice is available upon request by calling 360-923-2822 or online at **www.hca.wa.gov.**

Subscriber's signature _____ Date _____

Agency/Sub Agency	❑ New ❑ Recertification

Physician: Complete this section *(any fee for completion of this form is the responsibility of the subscriber)*

Physician's last name | First name | Middle initial

Mailing address	City	State	ZIP Code

Is this dependent capable of employment which would independently support himself/herself? ❑ Yes ❑ No

If yes, please indicate: ❑ Full-time ❑ Part-time

If no, please explain why under "Nature of disability" below.

Has disability existed continuously since before age 20? ❑ Yes ❑ No

If no, when did disability first exist?

Nature of disability, including diagnosis (please give as much detail as possible) _____

Prognosis (please estimate duration of disability) _____

I certify that, to the best of my knowledge and belief, the information I have provided is true and accurate.

Physician's signature _____ Date _____

Mail completed form to:
Washington State Health Care Authority
P.O. Box 42684
Olympia, WA 98504-2684

Washington State Health Care Authority
Public Employees Benefits Board

For Agency Use Only

❑ Approved ❑ Denied Effective date _____

Recert. date _____ Initials _____